

CITY KIDS DENTAL NORTH SHORE, LLC

PATIENT INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of the patient's medical record.

Patient Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
Preferred Appointment Times:	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
	<input type="checkbox"/> Any Time	<input type="checkbox"/> M	<input type="checkbox"/> T
	<input type="checkbox"/> W	<input type="checkbox"/> Th	<input type="checkbox"/> F
	<input type="checkbox"/> S		
Address (Street, City, State, ZIP)	E-mail:		

HEALTH INFORMATION

Date of Last Dental Visit:	Reason for last visit:		
Has your child had any of the following? Please check those that apply.	<input type="checkbox"/> AIDS	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> Allergies <i>Please list below</i>	<input type="checkbox"/> Growths	<input type="checkbox"/> Pregnancy <i>Due Date:</i>
	<input type="checkbox"/> Anemia	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Premature Birth
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Radiation Treatment
	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Respiratory Problems
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatism
	<input type="checkbox"/> Cancer	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Seasonal Allergies
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizure Disorder
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Problems
	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Stomach Problems
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Stroke
		<input type="checkbox"/> Tuberculosis	
		<input type="checkbox"/> Tumors	
		<input type="checkbox"/> Ulcers	
		<input type="checkbox"/> Venereal Disease	
		<input type="checkbox"/> Codeine Allergy	
		<input type="checkbox"/> Penicillin Allergy	
		OTHER: <input type="checkbox"/>	

Has your child ever had any complications following dental treatment? Y N

If yes, please explain:

Has your child been admitted to a hospital or needed emergency care during the past two years? Y N

If yes, please explain:

Is your child under the care of a physician? Y N

If yes, please explain:

Name of child's physician: _____ Physician's Phone #: () _____

List any other health problems that need further clarification:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child has any change in his/her health, I will inform the doctors at or before the next appointment without fail.

<i>Patient/Guardian Signature</i>	<i>Relationship to Patient</i>	<i>Date</i>
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REFERRAL INFORMATION

Whom may we thank for referring you to our practice?	<input type="checkbox"/> Dr.
<input type="checkbox"/> Family	<input type="checkbox"/> Friend
<input type="checkbox"/> School:	<input type="checkbox"/> Close to home/work
	<input type="checkbox"/> Ad in:
	<input type="checkbox"/> Other:
Name of person or office referring you to our practice:	